

CB Form-20 (Revised 5/02)

DATE: _____

TO: Compensation Board

FROM: _____

SUBJECT: Request for reimbursement of medical emergency services rendered to
_____, a "**state responsible**" inmate.
(Name of Inmate)

- PART A:
1. Offense Date: _____
 2. Social Security Number: _____
 3. Institution Number: _____
 4. Dates of current incarceration: From _____ To _____
 5. ***Date*** of prisoner's final felony conviction ***and identification of charges*** (e.g. larceny, rape, etc.):

 6. Length of sentence: _____

PART B: TO BE COMPLETED BY DOCTOR, NURSE OR OTHER QUALIFIED MEDICAL PERSONNEL—Medical description of nature of medical emergency. Illness or injury? If injury, how did it occur? (Please attach copy of discharge summary or an explanation as to why a copy cannot be obtained):

PART C: Has another request for reimbursement of medical bills been filed on this individual? YES NO If "yes", please provide date: _____

PART D: Total amount that has been spent by your locality for medical supplies for the jail and for medical services performed by hospitals, doctors, etc. outside your facility (this total should include expenses incurred for ALL other such emergencies since July 1 of the current fiscal year to date):

PART E: Determine your per diem estimate shown in the Compensation Board Jail Funding estimate available on the Compensation Board website (www.scb.state.va.us)

PART F: Total dollar amount budgeted by your facility for medical supplies and emergencies for the current fiscal year: \$ _____
NOTE: To qualify for reimbursement, this amount must be 10% or more of the amount show in paragraph E.

PART G: 1. Date or dates prisoner received treatment: _____

2. **To be completed by facility's LIDS Technician ONLY:**
WAS PRISONER STATE RESPONSIBLE ON DATES SHOWN BELOW WHEN SERVICES WERE RENDERED BY MEDICAL PROVIDER? YES NO (circle one)
(INQUIRE ON CONFINEMENT INFORMATION LIDS SCREEN, REASON 22 OR 28, TO SEE IF INMATE WAS STATE RESPONSIBLE. REFER TO DEFINITION OF STATE RESPONSIBLE INMATES IN APPROPRIATION ACT ITEM 67 – B.3. (a & b).

LIDS TECHNICIAN SIGNATURE: _____ **DATE:** _____

Date of Service	Service Rendered by Hospital/Doctor	Amount Claimed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
TOTAL		_____

I certify the above information is correct to the best of my knowledge and the attached invoices have been presented to the locality for payment. I also certify that I have adopted the Department of Corrections Model Plan for Jail Prisoner Medical Treatment Program.

_____ _____
Date Sheriff/Jail Superintendent

I certify the attached invoices have been paid by the locality.

_____ _____
Date Chief Disbursing Officer

NOTE: You need to retain an original copy of this form on file to photocopy each time a

request is made.

EXPLANATION OF ITEMS REQUESTED
ON CB FORM-20 (Revised 5/02)

- ADDRESS:
1. Date form is completed.
 2. Name and address of Sheriff's Department, Jail Farm or Regional Jail submitting request.
 3. Name of individual who received the medical services.
- PART A:
1. Offense Date
 2. Social Security Number
 3. Institution Number
 4. Beginning and ending dates of incarceration during which the medical emergency occurred. (If prisoner is still incarcerated at the time of request write PRESENT after TO.)
 5. Date of prisoner's final felony conviction and identification of charges (e.g., larceny, rape, etc.).
 6. Length of prisoners sentence **(must be two years or more if the felony was committed prior to 1/1/95, or one year or more if the felony was committed on or after 1/1/95, in order to qualify for reimbursement).**
- PART B:
- Please have doctor, nurse or other qualified medical personnel briefly describe the nature of the medical emergency. If emergency is result of an injury occurred. Finally, please submit a copy of the discharge summary or an explanation as to why a copy cannot be obtained.
- PART C:
- If you have previously filed for reimbursement for this individual please indicate by responding "YES" and give date.
- PART D:
- Please indicate the total amount that has been spent to date by your locality for medical supplies for the jail and for medical services performed by hospitals, doctors, etc. outside of your facility (i.e., this total should include expenses incurred for all other such emergencies since July 1 of the current fiscal year to date.)
- PART E:
- Determine your per diem estimate shown in the Compensation Board Jail Funding estimate available on the Compensation Board website (www.cns.state.va.us/compboard)

PART F: Total dollar amount budgeted for your facility for medical supplies and emergencies for the current fiscal year. (To qualify for reimbursement, this amount must be 10% or more of the amount shown in paragraph E, above.)

PART G: 1. Date or dates prisoner received treatment.

2. Determine if prisoner was state responsible.

3. Provide the name of the doctor, hospital or professional providing medical service.

4. Amount of invoice or portion of invoice for which you are requesting reimbursement.

NOTE: The information for Items 1, 2 and 3 is to be taken from the invoice and the information to be entered in these columns is to be a summary total of each invoice.

5. Date and signature of Sheriff, Jail Superintendent or Jail Farm Superintendent which certifies that information is correct, and that the Sheriff has adopted the Department of Corrections Model Plan for Jail Prisoner Medical Treatment Program.

6. Date and certification by locality of payment to the health care provider.

NOTE: The Compensation Board will not consider reimbursement unless it is certified the invoice has been paid by the locality.